

Name:					DOB:	
Date of Examination:				(within one year of matriculation)		
B/P	_Temp	Pulse		_WGT	HGT	
Allergies:	<del> </del>	Me	dicatio	n:		
Reason for symptom Assessment:						
To Be Completed by a Health Care Provider						
Has the student/p problems with a p	patient experienced ar persistent cough?	ny				
Has the student/p in their sputum?	patient noticed any blo	ood				
Has the student / p night sweats?	oatient experience any	У				
Has the student/ precently?	oatient had a fever					
•	oatient experienced lo r weight loss lately?	OSS				
Does anyone the sassociates with ha	•					

Has the student/patient seen a healthcare